IF YOU HAVE ANY QUESTIONS,
PLEASE CALL: **461-3141** / FOR SHORT STAY: **461-3183**
THIS IS A NON - SMOKING FACILITY

DAMERON HOSPITAL ASSOCIATION
525 West Acacia Street • Stockton, California 95203
Phone 944-5550

PRE-ADMISSION INFORMATION

Dear Patient,
Your doctor's office has informed us that you are scheduled for surgery on _____.
So that we may admit you to your room without unnecessary delay we would appreciate your completing this pre-admission form and returning it to us. Please be sure the information provided is accurate and given in detail, particularly all insurance, Medi-Cal, or Medicare numbers. This will enable us to have all your admission papers typed and ready for your signatures upon your arrival at the hospital. Please **DO NOT** bring jewelry or valuables to the hospital. We strive to provide the type of room requested, but we cannot guarantee this.

PLEASE RETURN FORM IMMEDIATELY

Doctor _____ Date due in hospital _____ ☐ OB ☐ Surgery

OB Maiden Name _____

I. PATIENT INFORMATION

Name _____ (LAST / FIRST / MIDDLE) Date of Previous Admission _____ (UNDER WHAT NAME)

Street Address _____ (NUMBER AND STREET / CITY / STATE / ZIP) Phone _____

Mailing Address _____ (NUMBER AND STREET / CITY / STATE / ZIP)

Sex _____ Birthdate _____ Age _____ ☐ Married; ☐ Single; ☐ Widowed; ☐ Separated; ☐ Divorced

Birthplace (State) _____ Religion _____ Social Security No. _____

Employer _____ Occupation _____ How long with present Employer? _____

Employer's Address _____ (NUMBER AND STREET / CITY / ZIP) Phone _____

Were you a patient in any other hospital within the last six months? _____

II. SPOUSE OR NEAREST RELATIVE

Name _____ (LAST / FIRST / MIDDLE) Relationship _____ Phone _____

Address _____ (NUMBER AND STREET / CITY / ZIP) Social Security Number _____ DOB _____

Employer _____ Occupation _____ Birthplace _____

Employer's Address _____ (NUMBER AND STREET / CITY / ZIP) Phone _____

How long with present employer? _____

III. IF A PATIENT IS A CHILD, COMPLETE INFORMATION FOR BOTH PARENTS

Father _____ (LAST / FIRST / MIDDLE)

Address _____ (NUMBER AND STREET / CITY / ZIP)

Phone _____ SS# _____ Date of Birth _____

Birthplace _____

Employer _____

Employer's Address _____ (NUMBER AND STREET / CITY / ZIP)

Work Phone no. _____ Occupation _____

How long with present employer? _____

Mother _____ (LAST / FIRST / MIDDLE)

Address _____ (NUMBER AND STREET / CITY / ZIP)

Phone _____ SS# _____ Date of Birth _____

Birthplace _____

Employer _____

Employer's Address _____ (NUMBER AND STREET / CITY / ZIP)

Work Phone no. _____ Occupation _____

How long with present employer? _____

IV. INSURANCE INFORMATION

Medicare # _____ Medical # _____ Issue Date _____ Kaiser # _____

Primary Insurance _____ ID # _____ Policyholder _____

Address and Telephone No. _____

Secondary Insurance _____ ID # _____ Policyholder _____

Address and Telephone No. _____

Worker's Compensation _____ Address _____

Date and Time of Injury _____

ADVANCE DIRECTIVES: Have you completed an Advance Directive? ☐ Yes ☐ No
(If yes, please bring a copy for your Medical Record if you have not done this in the past.)

Do you have special needs that we should be aware of? (i.e. language assistance, TTY disability) Please let us know so we can better assist you on your admission: _____

8560-186 (4/24/07)